ARIZONA DEPARTMENT OF HEALTH SERVICES
CHILDREN'S REHABILITATIVE SERVICES (CRS)

Please send this form to the clinic nearest you:

124 W. Thomas Rd., Phoenix, AZ 85013 (800) 392-2222 Tel-(602) 406-5731 or Fax-(602) 406-7166
2600 N. Wyatt Dr., Tucson, AZ 85712 (800) 231-8261 Tel-(520) 324-5437 or Fax-(520) 324-3084
1200 N. Beaver, Flagstaff, AZ 86001 (800) 232-1018 Tel-(928) 773-2054 or Fax-(928) 773-2286
2400 Avenue A, Yuma, AZ 85364 (800) 837-7309 Tel-(928) 336-7095 or Fax-(928) 336-7497

CRS APPLICATION FORM

TODAY'S DATE:

CHILDÕS NAME (Last, First, Middle)	RACE	SEX Ï M Ï F	DATE OF BIRTH (mo/day/yr) / /
PARENT OR GUARDIAN (Last Name, First Name)		RELATIONSHIP TO CHILD Ï Natural Parent (s) Ï Adoptive Ï Foster Ï Other	
CHILDÕS ADDRESS STREET CITY STATE ZIP CODE COUNTY			US Citizen Yes or No
HOME TELEPHONE ( ) -	MESSAGE /CELL PHONE NUMBER ( ) -	WORK PHONE NUMBER ( ) -	E-MAIL ADDRESS
IN EMERGENCY NOTIFY (Name, Relationship, Address, Telephone)			
CHILDÕS Primary Care Practitioner	ADDRESS	PHONE NUMBER	
REFERRED BY: (Name, address, phone) (This individual verifies that the childÕs parent/guardian has been notified about this referral.)			
REASON FOR REFERRAL TO CRS:			
LIST PRIMARY DIAGNOSES (e.g., Cleft Lip, VSD, Cerebral Palsy, etc.) IF AVAILABLE, **PLEASE SEND RECORDS WITH THIS FORM**. 1) 4) 2) 5) 3) 6)			
LIST ANY KNOWN ALLERGIES 1) 2) 3) 4)			
HAS CHILD RECEIVED CRS SERVICES BEFORE?: Ï YES Ï NO	YEAR?	WHERE?	PRIMARY LANGUAGE?
NAME OF PERSON WHO COMPLETED THIS FORM	ADDRESS	PHONE ( ) --	RELATIONSHIP TO PATIENT

PERMISSION TO OBTAIN RECORDS

I hereby authorize and request the CHILDRENÕS REHABILITATIVE SERVICES through the authorized contractors, to request and obtain photocopies of medical records concerning the above named patient:

Obtain records from:
Primary Care Practitioner_____Address: _____

Specialist: _____ Address: _____

Specialist: _____ Address: _____

Therapist/Education: _____ Address: _____

This consent will expire one year after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify the ChildrenÕs Rehabilitative Services clinic in writing to that effect. I understand that a photocopy or facsimile of this authorization is considered acceptable in lieu of the original.

_____ _____
Signature of Consenting Party Date Relationship to Patient

AHCCCS PLAN [ ] YES [ ] NO HEALTH INSURANCE [ ] YES [ ] NO *Please include copy of insurance information or card.*

FOR CRS CLINIC USE ONLY				
APPLICATION REVIEWED BY:			DATE	Ï Approved
SPECIALTY CLINIC ASSIGNMENTS:				
Ï PEND- **diagnostic tests**	Ï PEND- **waiting for medical documentation**	Ï DENY- **no medical documentation**	Ï DENY-**not medically eligible**	Ï DENY ï **Other reason**